This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mycigna.com/shbp or by calling 1-800-633-8519 **or** www.myuhc.com/shbp or by calling l-877-246-4189.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network : / Out-of-network: • You $ 2,000 / $ 4,000 • You + Child(ren) $ 4,000 / $ 8,000 • You + Spouse $ 4,000 / $ 8,000 • You + Family $ 4,000 / $ 8,000	You must pay all negotiated costs until the deductible is satisfied before this plan begins to pay for certain covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	
Is there an out-of-pocket limit on my expenses?	Yes. In-network : / Out-of-network: • You $ 4,500 / $ 9,000 • You + Child(ren) $ 9,000 / $ 18,000 • You + Spouse $ 9,000 / $ 18,000 • You + Family $ 9,000 / $ 18,000	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and any non-covered services this plan doesn't cover.	Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

Questions: Call 1-800-610-1863 or visit us at **www.dch.georgia.gov/shbp for additional information including a copy of your plan's summary plan description.** If you aren't clear about any of the underlined terms used in this form, see the SBC Uniform Glossary. You can view the SBC Uniform Glossary at www.dch.georgia.gov/shbp or call 1-800-610-1863 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See www.mycigna.com/shbp or by calling 1-800-633-8519 **or** www.myuhc.com/shbp or by calling l-877-246-4189 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting below for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without obtaining a referral from your primary care physician.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	None
	Specialist visit	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Other practitioner office visit	20% co-insurance for chiropractor	40% co-insurance for chiropractor	
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.dch.georgia.gov/shbp.**	Generic drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
	Preferred brand drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
	Non-preferred brand drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
	Specialty drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Physician/surgeon fees	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need immediate medical attention	Emergency room services	20% coinsurance after satisfying the in-network deductible	20% coinsurance after satisfying the in-network deductible	
	Emergency medical transportation	20% coinsurance after satisfying the in-network deductible.	20% coinsurance after satisfying the in-network deductible.	
	Urgent care	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Physician/surgeon fee	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Mental/Behavioral health inpatient services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder outpatient services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder inpatient services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you are pregnant	Prenatal and postnatal care	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Delivery and all inpatient services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Rehabilitation services (Acute Short-term Rehabilitation)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year, in-network and out-of-network visits not to exceed 40 combined
	Habilitation services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year, in-network and out-of-network visits not to exceed 40 combined
	Skilled nursing facility services	20% coinsurance after satisfying the deductible	No coverage	Up to 120 days per Plan year
	Durable medical equipment	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Hospice service	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	0 cost, not subject to deductible	Not covered	One eye exam every 24 months
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Routine dental care
- Cosmetic surgery
- Infertility treatment

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Dental Coverage for prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury

See the SPD at **www.dch.georgia.gov/shbp** for more information

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 800-610-1863. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.com.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You should contact your health care vendor directly to appeal denial of coverage for claims. You should contact Cigna at 800-633-8519 or www.mycigna.com/shbp or UnitedHealthcare at 877-246-4189 or www.myuhc.com/shbp. For questions about your eligibility, rights, this notice, or assistance, you can contact: the State Health Benefit Plan Call Center at 1-800-610-1863 or access information about eligibility appeals at www.dch.georgia.gov/shbp.

To see examples of how this plan might cover costs for a sample medical situation see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,432
- **Patient pays** $3,108

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Co-pays	$0
Co-insurance	$1,108
Limits or exclusions	$0
Total	**$3,108**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $1,680
- **Patient pays** $2,420

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$2,000
Co-pays	$0
Co-insurance	$420
Limits or exclusions	$0
Total	**$2,420**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers,** costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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